

manifestations. The present case had annular lesions mimicking tenia infection and a depressed nose. Though annular lesions are frequently seen in secondary syphilis, they are rarely seen in congenital syphilis.³ However, well defined annular lesions with a raised border mimicking tenia infection have not been reported in congenital syphilis. We suggest that possibility of congenital syphilis should also be considered in infants presenting with asymptomatic annular lesions.

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Antitrichomonal (cross) immunity as an important factor in vulvar vestibulitis syndrome pathogenesis

Vulvar vestibulitis syndrome (VVS), characterised by tenderness and erythema of the vaginal introitus,¹ has not been aetiologically connected with an infective agent.² According to personal clinical observations, it seems that in this syndrome genital trichomoniasis is more rare than in the usual population of sexually active women. The aim of this letter is to point out the possibility that extragenital trichomonas infections, with consecutive sensitisation, including crossed circulating immunity, may also cause the manifestations of vulvar over-sensitisation and erythema in cases of trichomonas infection of the sexual partner's sperm.

In six women with VVS, which lasted more than 6 months, trichomonads (Ts) were searched for in cervicovaginal secretions, urine sediments, morning expectorated mucus as well as in the partner's fresh sperm (up to 1 hour after ejaculation). Wet smears were stained by standard methods and immediately microscopied. All materials were inoculated in Diamond's TYM medium³ enriched with 10% heat-inactivated horse serum and rice starch. Species identification was determined by microscopy of cooled wet preparations, wet smears and cultures of cervicovaginal secretions were negative in all six women. Smears of respiratory mucus showed the presence of flagellary T forms in four cases, while in the cultures *T tenax* was grown. *T vaginalis* was grown in cultures of urine sediment of the remaining two women and in sperm of five partners. Peroral or perrectal (by a heavy smoker with gastric ulcers) metronidazole, with instructions regarding respiratory mucus expectoration

(especially postural and postprandial), resulted in significant regression of vulvar symptoms in all women. In three cases with respiratory trichomoniasis, in both urine-positive women and in all five sperm positive partners, metronidazole removed the parasites. In the last woman (a heavy smoker) with respiratory trichomoniasis, metronidazole significantly reduced respiratory mucorrhea but smears remained positive. As all women used coitus interruptus as the main contraceptive method a condom was recommended after therapy.

In the voluminous literature about trichomoniasis, the association of chronic trichomonas infection and epithelial dysplasia is well known. Such an association has its parallel in the histopathological findings of the vulva affected by VVS.² Trichomonas more frequently colonise Caucasians and women aged between 20 and 30 years, which corresponds to the incidence of VVS. Monogamous sexual relations associated with monostain trichomonas infection (constant family isolate with stable antigenic battery and accommodated woman's immune apparatus) erode to a lesser extent the host-immunity, so enabling competent interspecific antitrichomonal cross-immunity. Aggressive vulvar hygiene with consecutive skin erosions, facilitates contact between host immune forces and trichomonas antigens (released intracellular proteases).

The very close relation of VVS with extragenital trichomoniasis in my patients is probably the consequence of host-parasite interaction on the basis of antitrichomonal immunity, which fails to clear up focal infection but which often successfully disables colonisation of trichomonas on distant mucous surfaces. Interspecies immunity may explain the absence of those parasites in the genitals of women affected by VVS although clinical symptoms and the pathological picture suggest their involvement. The results of this small series and the proposed concept suggest the need of detection/eradication of sexual partner's sperm trichomoniasis and extragenital trichomoniasis infections in VVS patients.

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Large loop excision of the transformation zone (LLETZ) or loop diathermy

Loop diathermy is a popular method of treatment for cervical intra-epithelial neoplasia (CIN) in gynaecology. There are a small but increasing number of operators who use this method in clinics of genitourinary medicine.

I write to report some of the findings on the past 100 patients, who have completed at least

six months follow-up, in whom I have used loop diathermy in a District General Hospital genitourinary clinic.

All 100 patients had loop diathermy performed only after prior colposcopically controlled biopsy had shown some degree of CIN. The initial pre-treatment colposcopy had been indicated by the presence of mild dyskaryosis, or worse, on cytology (89 women), cervical warts (7 women), or naked eye clinical suspicion of disease (4 women). In all women the upper margin of the transformation zone was colposcopically visible.

The age range was 18–42 years with a mean of 24.

Local anaesthesia was provided using 2.2 ml of Citanest, infiltrated intra-lesionally using a dental syringe. A Force 2 electro-surgical unit (Valleylab, Boulder, Colorado, USA) was used, in the monopolar mode, with a blended cutting and coagulation output of 40 + 40 watts respectively. The transformation zone was resected using Rocket disposable loops of 0.006" gauge wire leaving a 2–3 mm margin on all sides. At the end of the procedure the cut surface was further coagulated with a ball electrode, to achieve complete haemostasis. Sultrin cream was then squeezed into the resection area and upper vagina. All 100 patients have now completed at least six months follow-up, and detailed statistical analysis will be reported in a subsequent communication.

Practically, loop diathermy provides a very advantageous and efficacious method of treatment for such genitourinary patients. Histological examination showed the removal of one previously unsuspected adenocarcinoma, 18 CIN III, 47 CIN II, 29 CIN I and five patients in whom only warty or no pathology was identified.

All but three of these removals were considered to be histologically complete, and in those three women subsequent colposcopic examination at 6 months showed no recurrence. (This is probably due to extra tissue damage performed during coagulation).

No patient was admitted for primary haemorrhage. Four women returned with secondary haemorrhage (all associated with anaerobe infection) and only one of these was hospitalised (for 24 hours).

Of the 100 women re-colposcoped after 6 months, five have been shown to have some remaining CIN. (Four CIN I and one CIN II). All were associated with wart virus infection.

None of these patients waited for more than 3 weeks between diagnostic colposcopy and loop diathermy. This compares with a much longer wait for the same procedure organised by local gynaecologists.

Essentially loop diathermy is a safe, effective procedure which can be offered conveniently and quickly to genitourinary patients. It should save morbidity (both mental and physical) as well as time, and thereby be cost effective. Initial questioning reveals it to be very well tolerated by patients who appreciate the speed at which the procedure can be performed.

It should however, be undertaken only by

experienced operators, in departments where communication with gynaecological colleagues is productive, and access to resuscitation procedures and a gynaecological bed is immediate.

I shall report more detailed information regarding these patients in due course, but would recommend this procedure to colleagues.

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Sexually transmitted disease [STD] control

The Communicable Disease Surveillance Centre's ten year (1981–1990) review of the size and nature of the STD problem in England and Wales is welcome and timely.¹

The review shows a consistent and cohesive epidemiological picture based on new patient numbers, diagnoses, age, sex and sexual orientation. The role of adolescents, women and homosexuals/bisexuals is detailed. The conclusion is stated unequivocally: "The data emphasise the need for renewed efforts towards prevention and control".

The Committee of Enquiry Report regarding Public Health noted dangerously low levels of control of infectious diseases.² More than a ten year review is needed to show if this applies to STDs. Some of us suspect that it does, and suggest two long term retrospective studies to establish or refute the suggestion as fact or fiction.

The first need is a study of the geography of STDs in the UK. It would no doubt show disparities between districts in terms of cities, towns and suburban areas and even between comparable population densities. Such findings should help evolve markers of service efficiency. New patient numbers per 100 000 population, follow-up, incidence of complications and evidence of effectiveness of health education endeavours offer a basis. A detailed geographical study would also help ensure more even-handed deployment of resources and laboratory support. In areas of low prevalence the use of certain laboratory methodologies such as ELISA testing for chlamydia detection may give unacceptably high false positive test rates.

The annual returns made by genitourinary medicine clinics over the last half century can provide much of the data required for this study. The chances are that the results could lead to improved STD prevention and could help to identify suitable sentinel clinics in which complementary prospective studies could be performed.

The second proposed long term retrospective study concerns the tracing, testing and treating of the sex partners of infected patients.